New patient intake information

Last Name: _____ First Name: _____ MI: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Email Address: _____

SS#: _____ Date Of Birth: _____

Whom may we thank for referring you? (Physician Name): _____

Emergency Contact Name: _____ Ph #: _____

Was the reason for your visit due to an accident? ☐ YES ☐ NO

Was this due to an Auto Accident? ☐ YES ☐ NO If so, state where accident occurred? _____

Was this due to a work related accident? ☐ YES ☐ NO If so, date of injury? _____

Patient's Employer: _____ Phone#: _____

Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired - Retirement date: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced Student? ☐ Full-time ☐ Part-time

If you are a Medicare Patient, are you currently receiving Home Health for ANY reason? ☐ YES ☐ NO

If you are a Medicare Patient, have you had Physical or Speech Therapy at all since January 1st?

☐ YES ☐ NO If so, please tell us where? _____

Insurance Company: _____

Please give Insurance Card(s) to front desk to be copied for important information.

Are you the Insured? ☐ YES ☐ NO

If NO, please tell us Insured's Name: _____

Insured's Date of Birth: _____ Insured's Employer: _____

PAST MEDICAL HISTORY FORM
COASTAL PHYSICAL THERAPY & LYMPHEDEMA MANAGEMENT, LLC

PATIENT NAME: _____ **AGE:**_____ **DOB:**_____ **DATE:** _____

Are you presently working? Yes ☐ No ☐ **Date of Injury / Onset:** _____
Have you ever had these symptoms before? Yes ☐ No ☐

Have you had surgery associated with this problem? YES ☐ NO ☐
If yes, please list the approximate date and type of surgery: _____

Other Surgeries: _____

Primary Care Physician: _____ **Date of next Physician's visit:** _____
Referring Physician: _____

CHECK WHICH APPLY TO YOUR SYMPTOMS:

	YES	NO		YES	NO
Work related injury	☐	☐	Injury related to lifting	☐	☐
Motor vehicle accident	☐	☐	Injury related to falling	☐	☐
Cause unknown	☐	☐	Athletic / recreational injury	☐	☐
Recurrence of previous injury	☐	☐	OTHER	☐	☐

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Diabetes	☐	☐	Allergy to Aspirin	☐	☐
Chest Pain/Angina	☐	☐	Allergy to Heat	☐	☐
High Blood Pressure	☐	☐	Intolerance to Cold	☐	☐
Heart Disease	☐	☐	Other Allergies	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heart Palpitations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐
Headaches	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fractures	☐	☐
Are you pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Problems	☐	☐
Osteoporosis	☐	☐	Sexual Dysfunction	☐	☐
Bowel/Bladder Abnormalities	☐	☐	Nausea / Vomiting	☐	☐
Urine Leakage	☐	☐	Ringing in Ears	☐	☐
Asthma/Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver/Gall Bladder Problems	☐	☐	Special Diet	☐	☐
Smoking	☐	☐	Hypoglycemia	☐	☐
OTHER	☐	☐	Stroke / CVA	☐	☐

If you answered YES to any of the above, please briefly explain and give approx. date: _____

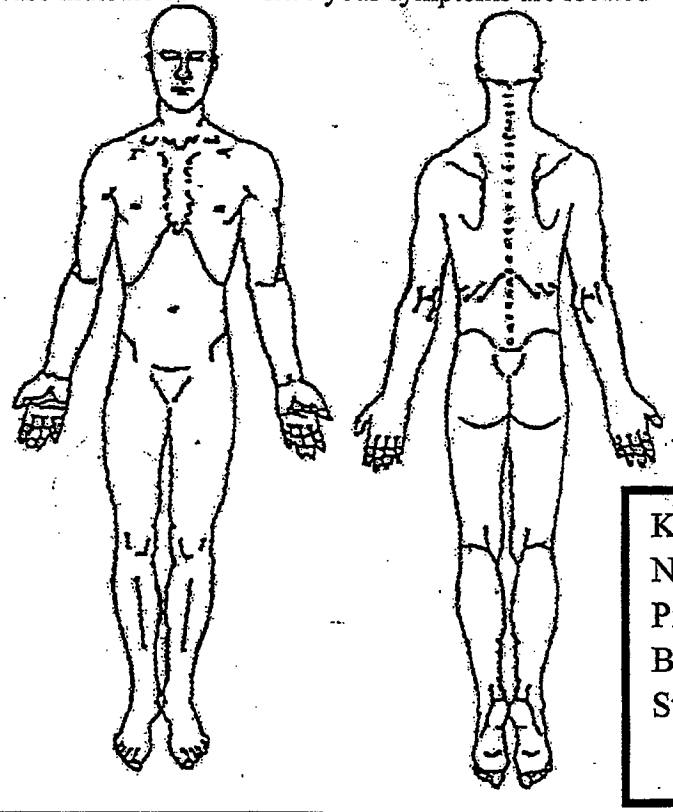
Is there any other information, regarding your past medical history, that we should be aware about? _____

Are you presently taking any medications? YES ☐ NO ☐
If YES, please list what medications and for what condition: _____

In the rare instance of an emergency, whom should we contact?
Name: Phone:

Do you participate in any sports, exercise programs, or activities on a regular basis? ☐ Yes ☐ No

Please indicate below where your symptoms are located



Key:
Numbness ═══
Pins & Needles oooooooo
Burning Pain xxxxxxxxxx
Stabbing Pain ////////////

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible: _____.

Patient's Signature Date Signature of Guardian if patient is a minor Date

Therapist Signature Date

CONDITIONS OF ADMISSION

Authorization for Treatment
I, the undersigned, hereby authorize and consent to rehabilitation services provided by COASTAL PHYSICAL THERAPY & LYMPHEDEMA MANAGEMENT, LLC, including any procedures which may be performed during this visit for:

_____.
Patient Name

Assignment of Insurance Benefits and Release of Information
I hereby authorize and assign direct payment to **COASTAL PHYSICAL THERAPY & LYMPHEDEMA MANAGEMENT, LLC,** of all insurance benefits payable to me under the terms of any insurance policy for the services rendered, but not to exceed the regular charge for services received. I authorize any holder of medical information about me, or any information needed to determine benefits payable for related services to be released to my insurance carrier, third party payer, and managed care organization or to any other insurance carrier, including Worker's Compensation claims. I authorize a copy of the authorization to be used in place of the original.

Medicare Patient Certification
I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf.

Medicaid Authorization and Assignment
I request that authorized Medicaid, Medigap or other Medical Assistance programs be made on my behalf to the above provider for services furnished to me by the provider/supplier. I authorize any holder of medical information about me or any information needed to determine benefits payable to be released to my insurance carrier. My signature certifies that I have received a service beginning with the date below. I understand that payment for this service will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State law.

Personal Valuables/Dependents/Visitors
It is understood and agreed that **COASTAL PHYSICAL THERAPY & LYMPHEDEMA MANAGEMENT, LLC,** is not responsible for loss or damage to any personal valuables and properties. In order to maximize safety, small children will not be allowed in the treatment area of the clinic. If older children are present, please keep them off the exercise equipment in order to prevent injuries. There may be exceptions; please ask if you have any concerns or questions. We will do everything possible to accommodate your schedule if you are the caretaker of small children.

Financial Agreement, Guarantee of Account
I, the undersigned, agree whether I sign as parent, guardian, spouse, agent, guarantor or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account to **COASTAL PHYSICAL THERAPY & LYMPHEDEMA MANAGEMENT, LLC,** in accordance with the regular rates and terms of the facility. I understand that therapy services are rendered and charged to the patient and not to the insurance company, and the facility cannot accept total responsibility for collection of claims nor for negotiating a disputed settlement. I agree to be responsible for all deductibles, co-insurance and non-covered portions of services performed. I understand that **COASTAL PHYSICAL THERAPY & LYMPHEDEMA MANAGEMENT, LLC,** is not a party to any lawsuit I may have due to litigation. I further understand that although information will be provided to my attorney, I am fully responsible to the provider for payment in full under the regular terms of the practice. Should the account be referred to an agency or attorney for collection, I shall pay actual attorney's fees and collection expense.

Notice of Privacy Practices
Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As indicated in our Notice, the terms of our Notice may change. If we change our Notice, you may request a revised copy. By signing below, you are stating that you have reviewed the Notice of Privacy Practices. Our Notice of Privacy Practices is posted in the waiting area, but you may request a written copy of the Notice at any time. You may also ask any questions about the Notice at any time.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS AND ACCEPT ITS TERMS

_____ _____ _____
Signature of Patient or Responsible Party | Relationship to Patient | Date

_____ _____
Witness | Date

Patient Authorization for Use / Disclosure of Protected Health Information

COASTAL PHYSICAL THERAPY & LYMPHEDEMA MANAGEMENT, LLC

PATIENT NAME: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

I hereby authorize COASTAL PHYSICAL THERAPY & LYMPHEDEMA MANAGEMENT, LLC to use and/or disclose any of my health information related to my current diagnosis, illness, and/or injury, to individuals and/or groups of individuals listed below (such as family, members of my household, close personal friends or anyone else) by my request so that all my rehabilitation needs may be met. The health information that I authorize to be used and/or disclosed is that information acquired during my care with COASTAL PHYSICAL THERAPY & LYMPHEDEMA MANAGEMENT, LLC and any health information that pertains to my care including past medical history and previous dates of service and those services received up to my discharge from COASTAL PHYSICAL THERAPY & LYMPHEDEMA MANAGEMENT, LLC.

Names of Individuals and/or Groups of Individuals I authorize COASTAL PHYSICAL THERAPY & LYMPHEDEMA MANAGEMENT, LLC to disclose my health information to.

_____

_____

_____

_____

** It is fine to leave a message on my answering machine in regards to appointments at COASTAL PHYSICAL THERAPY & LYMPHEDEMA MANAGEMENT, LLC.

By providing this Authorization, I understand as follows:

1. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected.
2. I understand that the health information to be released may be subject to re-disclosure by the recipient of the health information and no longer protected by the Federal Privacy rules.
3. I understand that I may revoke this Authorization at any time by notifying _____ in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.
4. I understand that I will receive a copy of this Authorization form after I sign it.
5. I understand that the Notice of Privacy Practices is posted in the clinic for my review. I also understand that a copy of the Notice is available to me, at my request.
6. I understand that this Authorization will expire on ___/___/_____ (DD/MM/YR) or upon the following event *(if for research put "None" or "End of the research study"):*

   _____

_____ _____

Signature of Patient or Patient's Representative Date

_____

Printed Name of Patient's Representative (if applicable)

_____

Representative's Relationship to Patient (if applicable)

Coastal Physical Therapy, LLC
Policy Regarding Missed Appointments
Important Notice for All Patients

Kindly give 24 hours advance notice if you are unable to keep your scheduled appointment time. If you see that you will be late for an appointment, please call and confirm that we will still be able to see you. If you are 15 minutes late or more, the staff has the discretion to reschedule your appointment or see you, depending on patient load.

Missed Appointment Policy

It is the policy of this office to require 24 hours advance notice for all appointment cancellations in order to allow the therapists maximum availability to all patients. To ensure availability is managed appropriately, it is necessary for Coastal Physical Therapy, LLC to have the following policy for missed appointments:

An appointment is considered **Missed** under any of the following circumstances:

- The patient is **more than 15 minutes late**
- The patient is a **No Show** for an appointment
- The patient does not give the proper advanced notice for **a cancel or a cancel/reschedule**

First Missed Appointment

The **pateint will be notified** of our office policy regarding missed appointments

Additional Missed Appointments

The **patient will be billed for a Missed Appointment charge of $25.00**. This charge is not covered by insurance and is the patient's responsibility. The missed appointment fee must be paid prior to future office visits.

Excessive missed appointments may compromise future scheduling.

INITIAL: _____